

Proviso 33.34

33.34. (DHHS: Medicaid Accountability and Quality Improvement Initiative) From the funds appropriated and authorized to the Department of Health and Human Services, the department shall implement the following accountability and quality improvement initiatives:

(A) Healthy Outcomes Initiative - Upon approval of the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services shall make available to participating hospitals up to a \$35,000,000 aggregate rate incentive effective October 1, 2013. This incentive shall be directly linked to a hospital's participation in initiatives designed to reduce system cost and increase health outcomes. To improve community health, the department may explore various health outreach, education and patient wellness and incentive programs. Working with Kershaw Health and its LiveWell Kershaw program, the department may pilot diabetes, smoking cessation, weight management, and heart disease interventions to identify the potential to offer such interventions as models for other hospitals to pursue. These initiatives may include, but are not limited to:

1. entering into a Memorandum of Understanding (MOU) with selected primary health care and other providers to co-manage chronically ill uninsured high-utilizers of emergency room services; and
2. participating in price and quality transparency efforts initiated by the department.

In designing these initiatives the department shall receive public input, and make the final determination of the initiative design. The department shall, no later than August 1, 2013, publish the manner in which participation in these initiatives will correspond with incentives. If at the end of the state fiscal year the department determines that this program is not generating cost savings or increasing health outcomes the department may retract this incentive in part or full.

(B) Disproportionate Share (DSH) Payment Accountability - Upon approval of CMS, in order to increase accountability for money reimbursed to hospitals under the DSH program and to improve outcomes for the uninsured, hospitals shall:

1. submit claims-level data for all individuals receiving uncompensated care; and
2. obtain a patient attestation to determine whether or not the individual receiving uncompensated care has access to affordable health insurance or does not have other means to pay for services.

(C) Rural Hospital DSH Payment - Upon approval of CMS, Medicaid-designated rural hospitals in South Carolina shall receive full coverage of uncompensated care as part of the State's Medicaid Disproportionate Share (DSH) program. Funds shall be allocated from the existing DSH program and shall not exceed \$20,000,000 total funds. Rural Hospitals are ineligible for this increased coverage should they not participate in reporting and quality guidelines published by the department and outlined in the Healthy Outcomes Initiative in the Fiscal Year 2013-14 Appropriations Act. These guidelines shall be published no later than August 1, 2013.

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In addition to the requirements placed upon them by the department, rural hospitals must actively participate with the department and any other stakeholder identified by the department, in efforts to design an alternative health care delivery system in these regions.

(D) Primary Care Safety Net - The department shall develop a methodology to reimburse safety net providers to provide primary care, behavioral health services, and pharmacy services for chronically ill individuals that do not have access to affordable insurance. Qualifying safety net providers are approved, licensed, and duly organized Federally Qualified Health Centers (FQHCs, entities receiving funding under Section 330 of the Public Health Services Act, and FQHC Look-A-Likes), Rural Health Clinics (RHCs), Free Clinics, other clinics serving the uninsured, and Welvista. No FQHC and FQHC Look-A-Likes operating under a management agreement or operated by a Chief Executive Officer who is not an employee of the entity is eligible to receive funds allocated by this proviso.

The department shall allocate at least \$5,000,000 for baseline funding to FQHCs as defined in paragraph (D), at least \$2,000,000 for documented capital needs for FQHCs as defined in paragraph (D), at least \$2,000,000 for baseline funding for Free Clinics, and at least \$5,000,000 for innovative care strategies for qualifying safety net providers.

The department shall consult with the SC Primary Health Care Association to determine the entities with the most critical capital needs. From the aforementioned \$14,000,000, Welvista shall receive at least an additional \$600,000.

To be eligible for funds, qualifying providers shall be required to provide the department patient and service data to assist in the overall improvement of the state's health quality and when appropriate safety net providers must enter into a MOU with hospitals to co-manage chronically ill uninsured high-utilizers of emergency room services. Participants in this program shall submit evaluations of effectiveness annually to the department.

(E) Rural Provider Capacity - The department shall incentivize the development of rural physician coverage and capacity building through the following mechanisms:

1. the department shall leverage the Graduate Medical Education program and develop a methodology to improve accountability and increased outcomes for the State's GME and Supplemental Teaching Payments investment by January 1, 2014; and
2. the department shall develop a program to leverage the use of teaching hospitals to provide rural physician coverage, expand the use of Telemedicine, and ensure targeted placement and support of OB/GYN services in at least four (4) counties with a demonstrated lack of adequate OB/GYN resources by July 1, 2014.
3. during the current fiscal year the department shall allocate \$4,000,000 to the MUSC Hospital Authority for telemedicine.

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(F) Community Residential Care Optional State Supplement - The department shall establish policies and procedures to include establishing a facility rate per eligible beneficiary at \$1,500 per month for recipients and providers who meet the requirements for the enhanced maximum OSS payment; establish eligibility criteria; and establish a methodology for increasing the personal needs allowance. The department will revise the net income limit to accommodate the change in the maximum OSS facility rate. A total of at least \$12,000,000 shall be made available for this rate increase. The facility rate shall increase a minimum of \$100 per month per eligible beneficiary. All current recipients shall remain eligible for the supplement during the fiscal year and nothing contained herein may conflict with or limit existing regulations.

In addition, the department will establish Quality of Care Standards and other requirements for facilities licensed as a Community Residential Care Facility and participating in the OSS program and Medicaid Waiver services.

(G) The department shall publish quarterly reports on the agency's website regarding the department's progress in meeting the goals established by this provision.